Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Brush Up on 4 Tips Before Reporting +99140 Emergency

Communicating with your provider is your best first step.

Including qualifying circumstances (QC) codes to your anesthesia claim adds base units to your total calculation, which means you want to report them whenever appropriate. Read on for the latest on how to correctly assess whether to submit +99140 (Anesthesia complicated by emergency conditions [specify] [List separately in addition to code for primary anesthesia procedure]).

Tip 1: Learn the CPT Definition of Emergency

The tricky part of reporting +99140 is verifying that you're truly coding for an emergency situation or condition. According to CPT® notes, "an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body parts."

Problem: "I find that quite a number of cases come in where the anesthesiologist marks off 'emergency' but neglects to include what makes the case an emergency," says **Leslie Johnson, CPC, CSFAC,** manager of coding, compliance, and education for Somnia, Inc., in New Rochelle, N.Y.

Solution: The first step in clarifying +99140 use is to have an open dialogue with the anesthesiologist. "The coder needs to sit down and have a heart-to-heart with the anesthesiologist regarding the emergency anesthesia circumstances," Johnson says.

Example: Johnson gives this hypothetical, but quite common, scenario. "There are times when a patient with abdominal pain will be found to have appendicitis, and is considered an emergency case, yet the patient was in observation or has been admitted for a time prior to the surgery," she says.

Explanation: "What nullifies the emergency in the above example is that many hours may go by before the admission," Johnson adds. "This could allow the anesthesia providers to get a good H&P from the patient, allow tests to be performed, and allow the ED staff (or surgeon) to get the patient stabilized out of the acute emergency stage where there is the possibility of loss of life or limb. When the possibility of loss of life or limb is decreased or no longer an issue then the 'emergency' goes away."

If the patient's appendix ruptures, however, the admission could be considered an emergency.

Tip 2: ER Admission Doesn't Always Mean Emergency

You'll sometimes see an anesthesiologist report a case as an emergency because the patient was admitted via the emergency room (ER), Johnson says. But don't jump to coding conclusions.

"Sometimes the anesthesiologist marks 'emergency' on the record because of the route [the patient] entered into the hospital, not because it's an actual life-threatening event which requires action at this particular moment," Johnson says.

Instead: If there is a real reason for reporting an emergency, your physician should document that reason, and you should report a more descriptive diagnosis code telling the carrier that the situation was not routine. For example, any of the 661.xx (Abnormality of forces of labor) ICD-9 codes can help support classifying a delivery as an emergency not the

fact that the mom-to-be was admitted through the ER.

Tip 3: Distinguish 'Unexpected' From 'Emergency'

Some physicians maintain that unexpected events qualify as emergencies. For example, they might indicate "emergency" for any service provided after normal hours or on weekends. Remember, however, that the time of day doesn't determine an emergency.

Definition: For the purposes of reporting code +99140, the RVG Guide defines an emergency as a situation when delaying a patient's treatment would lead to a significant increase in the risk to the patient's life or limb.

Best bet: Talk to the anesthesiologist directly for a more thorough account of the encounter you are reporting to determine whether the encounter merits +99140.

Tip 4: Payer Guideline Knowledge Is Power

Knowing which payers recognize QC codes and reimburse accordingly can provide more than enough payoff. Because of that, always discuss qualifying circumstances when you negotiate contracts with non-government payers (Medicare does not reimburse for qualifying circumstances). Medicaid does not negotiate for separate payment, although some states Medicaid programs pay separately for qualifying circumstances and/or physical status.

Good idea: Include a contractual clause stating whether your specific payer reimburses based on the ASA RVG. That way you can provide a copy of the RVG page and remind the representative of your contract in case you receive a denial. Don't presume these services are not covered always check with state carrier published policies.

Experts note: Payers won't reimburse or they may pay at a lower rate based on their perception of how others in the same specialty are performing. If no one bills for a service, such as + 99140, eventually the payer will no longer allow the particular code. If billing continues for the service, however, insurers could see it as a viable and billable service and may consider allowing reimbursement.

"Watch out for the payer rules and check with your compliance officer or healthcare attorney to see if it's appropriate to continue billing for a published non-covered service," Johnson says. "You don't want to risk getting into a compliance issue in that Medicare may regard billing a non-covered code as disregard for their rules."

Caveat: As with many coding situations, there are exceptions to this coding rule. You should not automatically add QC codes to your claim when Medicare and Medicare-following carriers explicitly state that a specific code is not payable under any circumstances.